Medicaid: Managed Care and Health Reform Opportunities and Key Considerations for The State of Montana

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COMMUNITY & STATE

CHILDREN & FAMILIES INTERIM COMMITTEE
NOVEMBER 14, 2011
Exhibit 22

About UnitedHealthcare's Experience

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UnitedHealthcare Benefits

UnitedHealthcare EMPLOYER & INDIVIDUAL

- **Individuals Served: 25M people**
- **Serves employers ranging from sole proprietorships to large, multi-site and national employers, students and individuals**

UnitedHealthcare MEDICARE & RETIREMENT

- **Individuals Served: 9M people**
- **Operates the largest business in America dedicated to the health and well-being of individuals over age 50.**

UnitedHealthcare COMMUNITY & STATE

- **Individuals Served: 3M people**
- **Manages health care services for state Medicaid and other publicly funded programs and their beneficiaries.**

Optum Health Services

OPTUMHealth™

- Individuals Served: 58M
- A national leader in health and wellness services
- Operates the only major bank dedicated exclusively to the health care industry
- Helps consumers navigate the health care system, finance their health care needs and better achieve their health and well-being goals

OPTUMInsight™

- Individuals Served: N/A
- A leader in the field of health care information, services and consulting
- Operates in more than 50 countries
- Clients include hospitals, physicians, health care payers, *Fortune* 500 companies, governments, health insurers and pharmaceutical companies

OPTUMRx™

- Individuals Served: 12M
- One of the largest pharmacy benefit managers in the United States
- Offers retail, mail order, specialty pharmacy and clinical services
- Serves employer groups, union trusts, seniors and commercial health plans

Medicaid Business

- *25 States + DC*
- *Payment Models: Full Risk & Managed Services – mix of mandatory enrollment*
- *Medicaid: TANF, CHIP, Childless Adults, Dual SNP, ABD, HCBS, Foster Care, Special Needs Children, DD/D, SSI*
- *Operate under multiple waivers: 1115, 1915(c), HCBS*
- *Delivery Systems: Accountable Care, ACA Health Homes, Medical Homes, Personal Care Model, PCP Gatekeeper*
- *HIT Enablement: Medical Home Population Registries, HIE, eMR, Risk Stratification, EBM, Enrollee Exchanges*

The LewinGroup - Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies - March 2009

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The studies present compelling evidence that Medicaid managed care programs can yield savings. The studies also suggest that certain populations or services are especially likely to generate savings in a managed care delivery system. We summarize these findings below.

- **First**, the studies strongly suggest that the Medicaid managed care model typically yields cost savings. While percentage savings varied widely (from half of 1 percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting
- **Second,** the studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related population.
- **Third**, various studies demonstrated that states' Medicaid managed care cost savings are largely attributable to decreases in inpatient utilization.
- **Finally,** pharmacy was also an area where Medicaid managed care programs yielded noteworthy savings.

Our Understanding of Montana's Current Managed Care Environment

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1. *Passport to Health* waiver section 1915(b)

- *Network: contracted PCPs*
- *Membership: 70% of enrollees*
- *CM Model: PCP & Authorizations required for out-of-network*
- *Cost: $3 PMPM and state at-risk for medical costs*
- *Exclusions: Duals, Nursing Home and Foster care*

2. *Health Improvement Program* waiver 1915(b)

- *Network: 13 FQHCs & 1 Tribal Center*
- *Membership: 3000 with acute conditions & expected high costs*
- *CM Model: Care coordination services (such as appointment reminders, arranging transportation, medication review)*
- *Cost: $3.75 PMPM and state at-risk for medical costs*

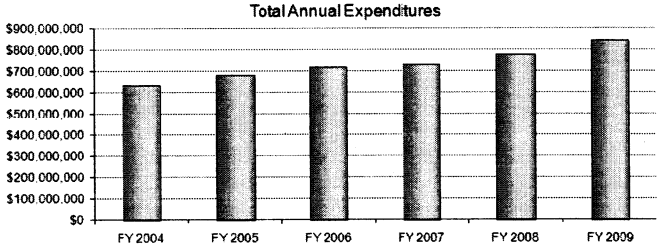
3. *Team Care* waiver section 1915(b)

- *Network: contracted PCPs*
- *Membership: Enrollees with above average claims costs*
- *CM Model: 24 hour nurse line with care from one PCP & one Rx*
- *Cost: $6 PMPM and state at-risk for medical costs*

4. *Other state programs under 1115 & HCBS*

Total Spend is about $900M – significant increase in enrollment in 2010 especially children -> June '10 at 64K up 20k from 2009.

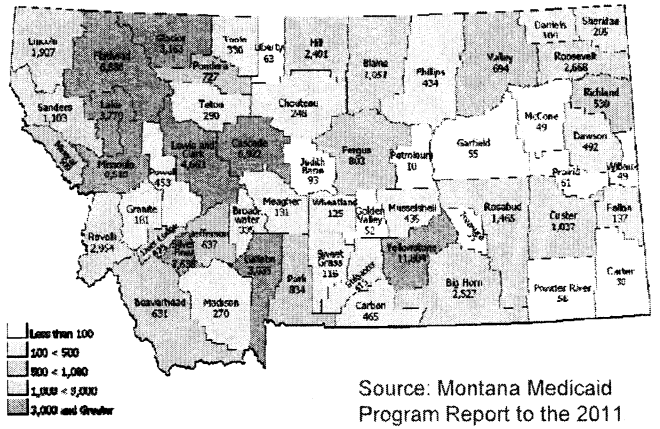
History of Expenditures and Enrollment



SFY 2009 Enrollment and Expenditures by Major Aid Category

Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	6,126	7.5%	$162,599,916	19.4%
Blind and Disabled	19,059	23.4%	$393,322,855	47.0%
Adults	11,433	14.0%	$111,604,852	13.3%
Children	44,979	55.1%	$169,336,452	20.2%
Total	81,597	100%	$836,864,075	100%

Medicaid Average Monthly Enrollment
State Fiscal Year 2009



Source: Montana Medicaid Program Report to the 2011 Legislature

Medicaid Expansion: Anticipated Health Experience

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- In 2010, UnitedHealthcare participated in a project with the Center for Health Care Strategies (CHCS) and select states to understand the needs of the Medicaid Expansion population.
- Specific programs and results vary from state to state, but the overall findings are consistent:
- These individuals are characterized as follows:
  - Poor* and low-income adults
  - Do not live with an eligible child (childless)
  - Do not have a disability
  - Higher rates of uninsured
  - Relatively high health care needs

Characteristics	AZ	IN	PA	ME	OR	NY
On average, childless adults more cost per year than the TANF population	✓			✓	✓	
On average, individuals at the lower end of the poverty scale incur disproportionately high costs			✓			✓
Childless adults tend to be associated with high utilization (particularly for services related to chronic conditions, mental health, and substance abuse)		✓			✓	

Health Care Reform Expansion in Montana

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84% Expansion Increase
76,000+ New Enrollees
$2.5+ Billion Increase

Estimated 2019 net enrollment increases under new federal Medicaid eligibility thresholds, compared to absence of the new federal health reform legislation

State	Expansion Enrollment	% Increase
Alabama	372,860	46%
Alaska	44,590	46%
Arizona	334,430	45%
Arkansas	257,790	45%
California	2,033,410	27%
Colorado	271,820	57%
Connecticut	133,020	26%
Delaware	8,260	5%
District of Columbia	13,090	7%
Florida	1,050,860	42%
Georgia	598,070	40%
Hawaii	13,440	6%
Idaho	86,680	42%
Illinois	542,150	23%
Indiana	424,630	45%
Iowa	156,250	40%
Kansas	168,090	57%
Kentucky	294,930	36%
Louisiana	456,640	45%
Maine	26,060	9%
Maryland	274,430	45%
Massachusetts	-6,140	-1%
Michigan	661,930	37%
Minnesota	110,460	16%
Mississippi	290,470	47%
Missouri	396,240	46%
Montana	76,640	84%
Nebraska	100,850	49%
Nevada	159,430	72%
New Hampshire	62,440	47%
New Jersey	376,250	41%
New Mexico	121,780	26%
New York	41,880	1%
North Carolina	583,470	40%
North Dakota	36,200	60%
Ohio	694,410	35%
Oklahoma	241,900	40%
Oregon	216,110	52%
Pennsylvania	818,470	36%
Rhode Island	42,440	23%
South Carolina	319,440	34%
South Dakota	48,040	45%
Tennessee	332,020	23%
Texas	1,904,390	56%
Utah	157,970	66%
Vermont	-7,310	-5%
Virginia	396,440	51%
Washington	328,270	32%
West Virginia	165,940	46%
Wisconsin	174,640	20%
Wyoming	33,680	52%
Total United States	**16,430,120**	**32%**

Figure 1.2; Source: UnitedHealth Center for Health Reform analytical modeling

State-specific estimated costs of proposed Medicaid expansion
(millions of dollars, 2014 – 2019) (excluding CHIP impacts)

	Total	Federal	State
Alabama	12,215	11,565	650
Alaska	1,475	1,370	105
Arizona	5,090	4,875	215
Arkansas	8,425	7,970	455
California	34,190	32,415	1,775
Colorado	5,095	4,820	275
Connecticut	3,170	3,035	135
Delaware	285	265	20
District of Columbia	555	530	25
Florida	29,785	28,060	1,725
Georgia	19,505	18,350	1,155
Hawaii	410	385	25
Idaho	2,780	2,665	115
Illinois	12,560	12,035	525
Indiana	12,565	12,040	525
Iowa	2,610	2,500	110
Kansas	5,170	4,785	385
Kentucky	9,775	9,210	565
Louisiana	14,495	13,690	805
Maine	865	830	35
Maryland	6,065	5,545	520
Massachusetts	125	120	5
Michigan	11,170	10,660	510
Minnesota	3,980	3,815	165
Mississippi	9,290	8,765	525
Missouri	8,955	8,560	395
Montana	2,490	2,340	150

	Total	Federal	State
Nebraska	3,310	3,140	170
Nevada	2,815	2,580	235
New Hampshire	2,095	1,960	135
New Jersey	8,140	7,800	340
New Mexico	4,165	3,900	265
New York	2,405	2,305	100
North Carolina	18,900	17,895	1,005
North Dakota	830	785	45
Ohio	17,360	16,625	735
Oklahoma	6,510	6,135	375
Oregon	7,260	6,835	425
Pennsylvania	27,385	26,025	1,360
Rhode Island	1,060	1,015	45
South Carolina	7,745	7,320	425
South Dakota	1,240	1,185	55
Tennessee	9,080	8,700	380
Texas	59,520	55,350	4,170
Utah	2,540	2,400	140
Vermont	-165	-160	-5
Virginia	12,980	12,160	820
Washington	7,475	7,070	405
West Virginia	5,460	5,175	285
Wisconsin	4,255	4,075	180
Wyoming	975	935	40
Total United States	**$436.4 billion**	**$412.3 billion**	**$24.1 billion**

Figure 1.3; Source: UnitedHealth Center for Health Reform analytical modeling

Impact of the ACA on Medicaid in Montana

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- The Affordable Care Act (ACA) is projected to bring over 70,000 individuals into Montana's Medicaid program by 2019. This represents a substantial increase over the current number of Medicaid consumers in the State and many of the newly eligible will be childless adults.
- National studies suggest that this new Medicaid population may have different healthcare needs.
- If these national results are extrapolated to the State of Montana, we would expect the Medicaid Expansion population to differ from the current Medicaid population in the following ways:
  - More likely to consider themselves in fair or poor mental health and general health [1]
  - More likely to have two or more chronic conditions[1]
  - More likely to be associated with high utilization (particularly for services related to chronic conditions, mental health, and substance abuse) [2]

1. Source: "Childless Adults Who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package Childless Adults Who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package ". The Center for Budget and Policy Priorities. Available at: http://www.cbpp.org/cms/index.cfm?fa=view&id=3229
2. Source: "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." Available at: http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf

Physician Capacity in Rural Communities

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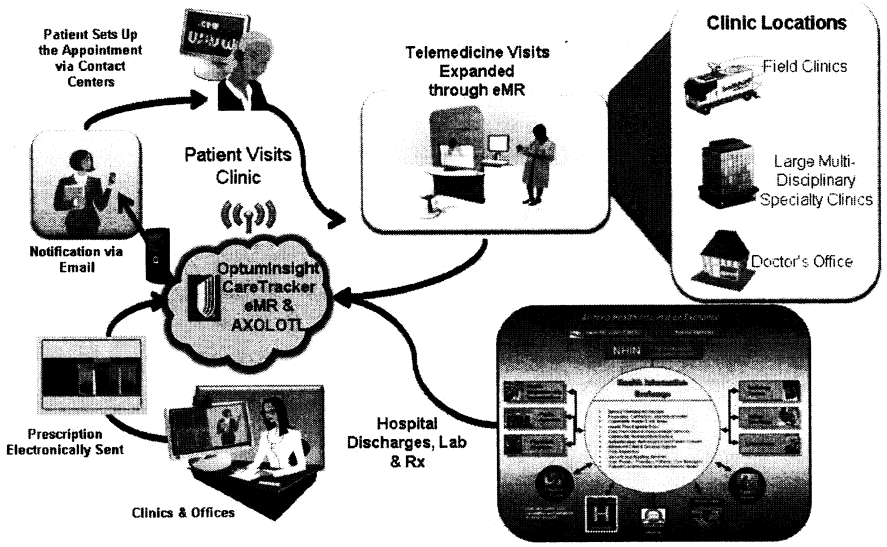
- The coverage expansions established by the Affordable Care Act (ACA) will place unique pressure on rural communities.
- Primary care plays a central role in delivering care within rural communities, yet in remote rural areas there are fewer than half the number of primary care physicians per 100,000 population than in urban areas.



- Primary care capacity will likely experience further strain as consumers gain new coverage through Medicaid and Exchanges.
- Scope of practice laws, which govern the scope of responsibility for nurse practitioners and other non-physician health professionals, may be one mechanism for relieving primary care capacity concerns.
- Other changes to the delivery system, such as Health Homes and Accountable Care Organizations (ACOs), e-Visits, Telemedicine may also help by improve primary care capacity, care coordination, and multidisciplinary teamwork.

Source: "Modernizing Rural Health Care: Coverage, Quality, and Innovation." UnitedHealth Group Working Paper #6. July, 2011. Available at: http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper6.pdf

Healthcare Reform offers Models aimed at CMS Triple Aim - Cost, Care, & Quality

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ACA Health Care Reform

MEDICAID:
Section 2403. Money Follows the Person Rebalancing
Section 2601. 5-Year Period for Demonstration Projects
Section 2703. Medical Home State Option
Section 2704. Integrated Care Around A Hospitalization
Section 2705. Medicaid Global Payment System
Section 2706. Pediatric Accountable Care Organization
Section 2707. Medicaid Emergency Psychiatric

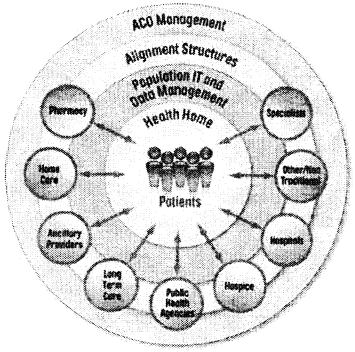
MEDICARE:
Section 3021. Center for Medicare and Medicaid Innovation
Section 3022. Medicare Shared Savings Program
Section 3023. National Pilot Program On Payment Bundling.
Section 3024. Independence At Home Pilot Program
Section 3502. Establishing Community Health Teams to Support Patient-Centered Medical Home

OTHER:
Section 4101. School Based Health Centers

Sec. 2703 – Health Home

- State option to provide health homes for enrollees with chronic conditions. Provide States the option of enrolling Medicaid beneficiaries with chronic conditions and behavioral health into a health home.
- ACA incentivizes state to pursue this option by authorizing a temporary 90% federal match rate (FMAP) for health home services.
- Effective January 2011.

Accountable Care Organizations



- ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers.
- Typically At-risk models
- Episode of Care Payments

Patient-Centered Medical Home

- Simplified and Coordinated Health Care Experience
- Improved Care Transitions
- Population Management Focused
- Evidence-based Medicine Driven

Evolution of Historical Managed Care Models to today's Accountable Care Communities

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Evolution through 2011 → *Today*

Independent Teams

- Utilization Management & Prior Auth
- ER Diversion
- Complex Cases
- Standalone Case Management
- Top 1%
- Impact Pro High Risk
- Disease Management
- Health Plan to Member Model

Multi-Disciplinary Team Approach

- Utilization Mgmt Multi-Disciplinary Team
  - Concurrent Review
  - Complex Case Management
  - ER Diversion
- CM / Disease Management
- Health Plan to Member Model

Community-Centric Approach

- Multi-Disciplinary
  - Concurrent Review
  - Complex Case Management
  - ER Diversion
- Collaborative Team
  - EBM Adherence
  - Patient Registries
  - Enhanced Patient Access
  - Care Advocate Role
  - Community-Based Services

- Patient-Centered Medical Home
- Accountable Care
- Guided Care Management
- Home & Community Based Services

Accountable Care Model

Support Resources

- Hospital UM
- Care Advocates
- Practice Consultants

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Example Impact of Movement to New Models of Care

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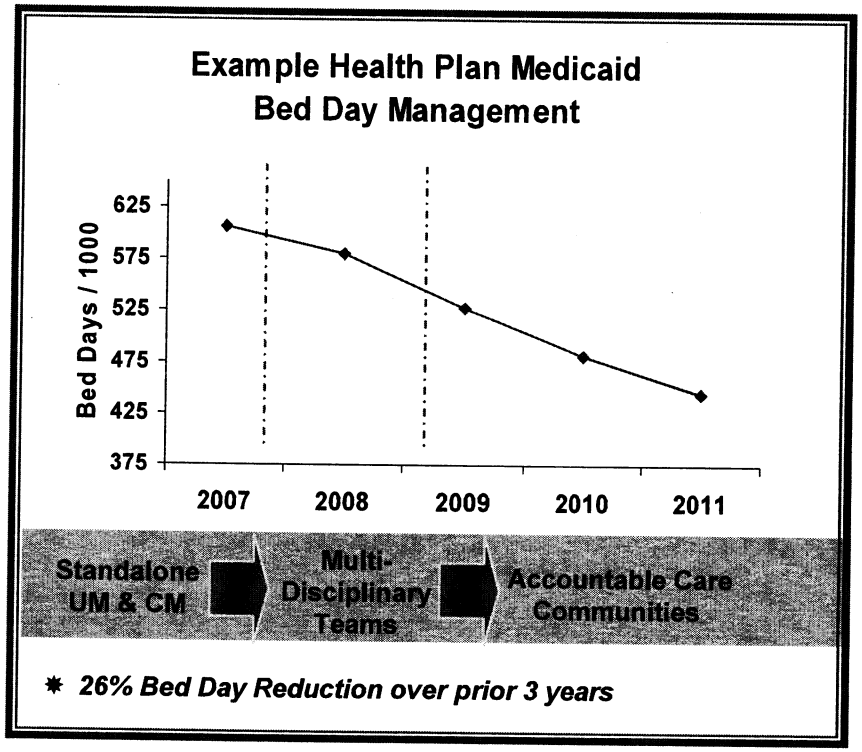
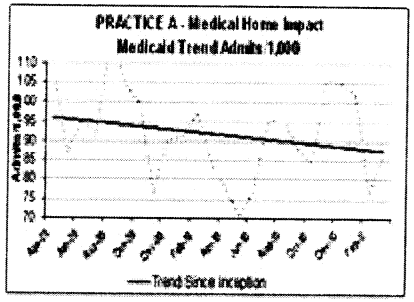
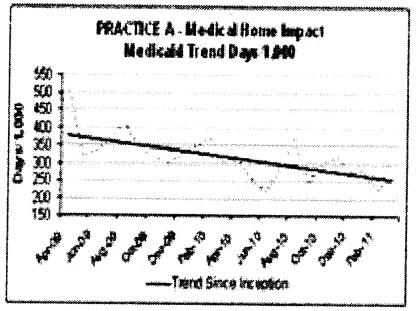


From Independent Utilization Management and Case Management to ***Accountable Care Communities***

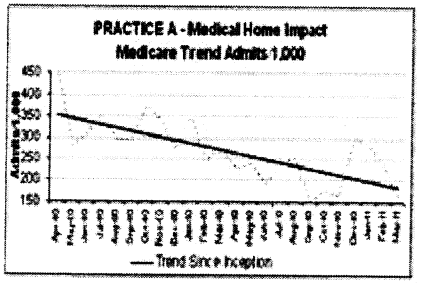
Example Medical Home Impact Since Program Inception

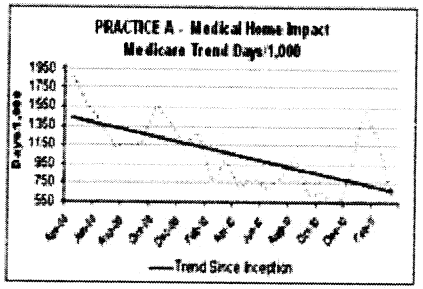
Medicaid admits/1,000 have decreased 17 percent, and bed days/1,000 decreased 26 percent:

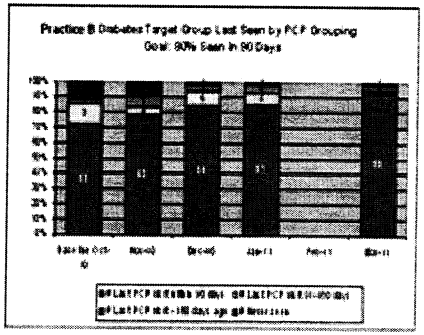


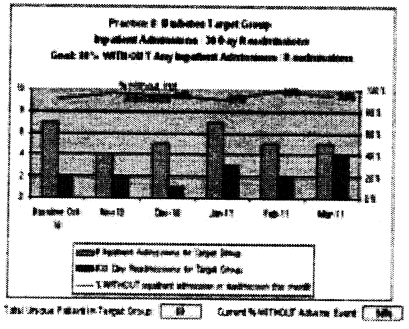


Medicare admits/1,000 have decreased 45 percent, and bed days/1,000 decreased 46 percent:









Dual Eligible Opportunity

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- ACA created opportunities to better integrate benefits for Dual Eligibles.
- The Federal Coordinated Health Care Office, is charged simplifying processes for Dual Eligibles, improving coordination between States and the Federal government, eliminating regulatory conflicts between Medicare and Medicaid, and ultimately improving the quality of healthcare for Duals.
- UnitedHealthcare Community & State aims to create a truly integrated Dual Eligibles Demonstration that is tailored to meet state needs and focuses on the following:
    - Member-centered integration of Medicare, Medicaid and applicable waiver benefits
    - Integration of all administrative functions, including member materials, and a seamless member experience
    - Development of a funding mechanism that provides incentives for improved utilization, benefits both Federal and state governments, and appropriately aligns incentives
- This opportunity could be leveraged by states regardless of whether they received federal grant funding to pursue a Dual Eligibles demonstration.

Medicaid Managed Care Best Practices in Moving to Full Capitation

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Factor	Most Common	Best Practice
RFP vs. Application	RFP – 60% use RFPs; most new states	RFP-TN, TX, OH, AZ, MI, PA, NV, CT, RI, DC, GA
Number of Plans	Limited: Rural 2-3, Metro 3-5	Limited: Rural 2-3, Metro 3-5 proportional to population; low rural population with high risk often just 1
Member assignment to new plans	New Plans receive auto-assigned members for defined period or to set threshold; rare- positive enrollment	Texas provided auto-assigns (if history matches network provider) to new plan for up to 15,000 members
Priced Bids	State sets 'take it or leave it' rates	States set rates (actuarially sound)
Access to Historical Claim Data	Yes	Yes – Nearly all states
Covered Populations	TANF, CHIP, Non-Dual/Non LTC ABD	All covered including Duals – TX, AZ, NY, TN
Benefit Carve Outs (Rx, BH, LTC, Dental)	Rx 10%, BH 25%, LTC 75%, Dental 35%	No Carve Outs - NY, TN, MI, WI, NE, RI, GA; TX has proposed Rx add back
Network Adequacy	Contracts, LOIs and Plan	Contracts, LOIs and Plan
Out of Network Payments	Limited to Medicaid Fee Schedule	5%-10% less than Medicaid
Open Enrollment	Annual with lock in 60%; others monthly option	Annual with lock in; few switch in 'open' states
Auto Assignment	Consider PCP history, Plan network, zip code	High-HEDIS plans gain preference MI, AZ, NY
Require PCMH / Accountable Care	No	Encourage adoption AZ, MI, HI. LA, NE, WI
Performance / Quality Incentives	Most have targets; few pay bonuses to plans; often penalties	Publicize plan performance TX, TN, PA, AZ, NY

Considerations for Heath Exchanges to Minimize Anticipated Churn

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A common phenomenon in Medicaid, a study published in Health Affairs demonstrates that there will be frequent movement between Medicaid and the Exchange as incomes fluctuate. Within a year 28 million or 50% of adults will experience a shift from Medicaid to the Exchange or vice versa.

The Exchange and Medicaid eligibility proposed rules appear to advance one critical step in a strategy to diminish churn as they emphasize the need and requirement for a seamless, one-stop shop enrollment process and a more simplified approach toward recertification.

- A single point of entry and eligibility determination, based on annual and current income
- A single application for eligibility (web, phone, in-person, mail)
- Significant reliance on attestations and pre-populated data from the Federal Hub, state wage reports and other sources when available
- Ability to complete the enrollment process, including plan selection online via the Exchange or through a link to Medicaid
- If the Exchange determines the applicant is eligible for Medicaid/CHIP, it must transmit that information to the State without requiring further steps to determine eligibility
- Annual recertification and auto-renewal when reliance on a data match is possible

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Appendix: Expansion & the Exchange

Expansion Projections (2019 View)

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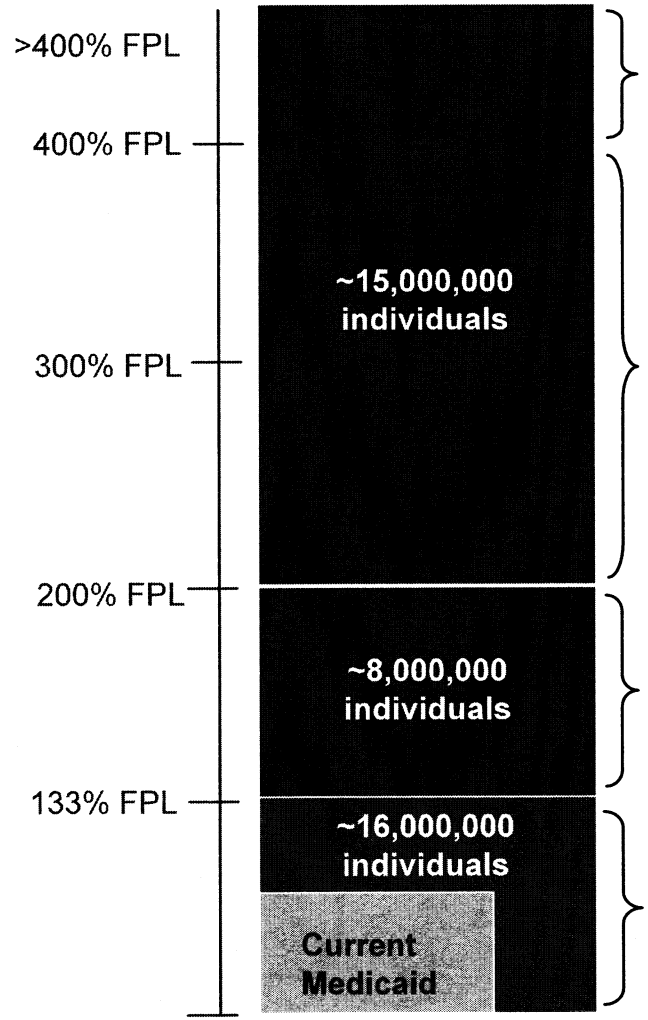

Non-subsidized coverage

Premium subsidies available to families with incomes between 133-400% FPL (to purchase insurance through the Exchanges)

States have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.

Medicaid Expansion: Uniform 133% FPL and new definition (Modified Adjusted Gross Income, or MAGI)

Note: This visual is scaled to FPL. Numbers do not necessarily reflect all net new coverage. Sourced from CBO estimates, available at: http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf

The Churn Phenomenon

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A common phenomenon in Medicaid, a study published in Health Affairs demonstrates that there will be frequent movement between Medicaid and the Exchange as incomes fluctuate. Within a year 28 million or 50% of adults will experience a shift from Medicaid to the Exchange or vice versa.

- Interestingly, the Health Affairs study introduction notes, "...research shows that 43 percent of newly enrolled adults in Medicaid experience a disruption in coverage within twelve months." (Sommers BD. Loss of health insurance among non-elderly adults in Medicaid)
- As it relates to the churn analysis, *" The sample was made up of adults ages 19–60 whose family income at the outset of the survey was 200 percent of poverty or less. Our sample included only adults, who constitute the population directly affected by the new Medicaid eligibility rules."*
- *"Our results show that 35 percent of the adults in our sample would have experienced a change in eligibility within six months, and 50 percent would have experienced a change within one year..."*
- *"Perhaps of even greater concern, 24 percent would have experienced at least two eligibility changes within a year, and 39 percent would have experienced such churning within two years."*
- Though states will need to conduct their own state specific evaluations, these findings suggest there will be considerable movement or churn between programs as incomes fluctuate.

Source: Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges" (February 2011)

Implications of Churn

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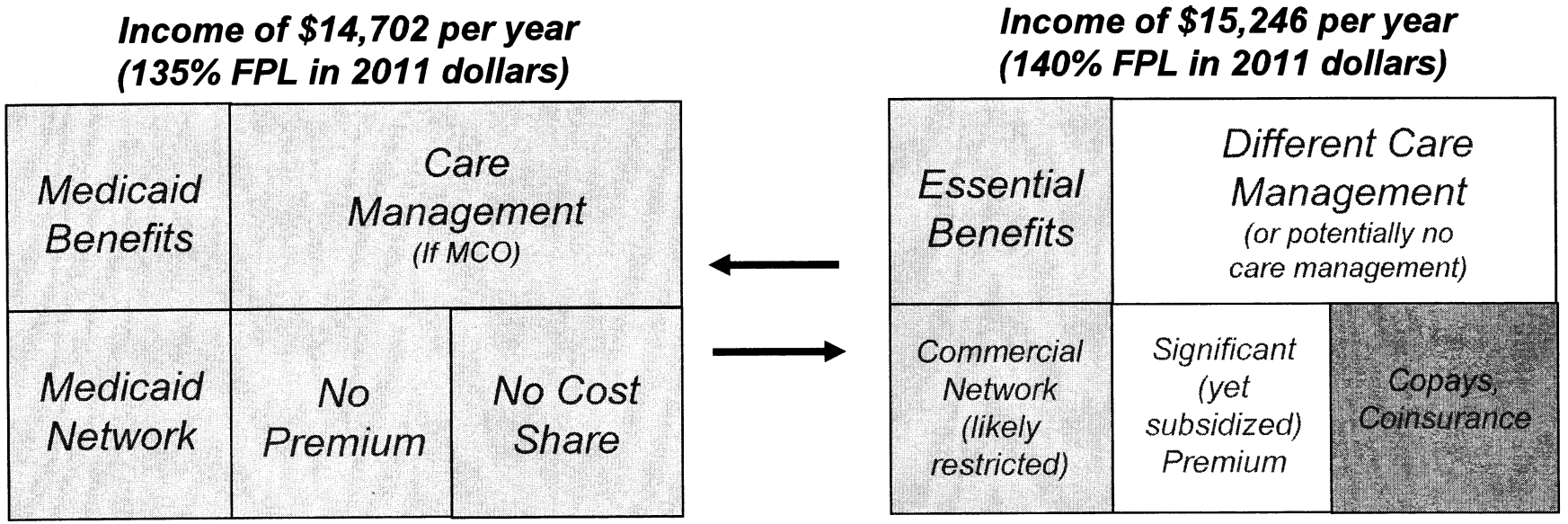
- Individuals with fluctuating income will move between Medicaid and Exchange eligibility.
- Key aspects of coverage, such as benefits, provider network, and out of pocket costs, may be disruptive and confusing.
- Though Exchange consumers at lower income levels will receive substantial premium subsidies, their cost to purchase coverage will be significant.
- Individuals experiencing such shifts may require additional support and assistance as they navigate the effects of coverage changes.



* *This diagram assumes that Medicaid covers up to 138% FPL and assumes no Basic Health Plan*

It's Impact On Consumers

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Absent strategies to address churn, frequent shifts between programs will cause confusion, disruption and continuity of care issues (access, benefits, services) for Maryland consumers.

- Can I still go to my doctor or health care professional?
- Which ID card should I use?
- Who do I call?
- Which program are my children in? How can our family stay together?
- Why isn't this benefit covered any more?
- I still don't have a car and need a ride to my doctor!
- I don't speak English, can a translator help me?
- Can I stay with my same health plan?
- What do you mean I have to pay for care (a new copay/premium for someone moving from Medicaid to the Exchange?)

And Then There Is The "Cliff"

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Though Exchange consumers at lower income levels will receive substantial premium subsidies, their cost to purchase coverage will be significant. Premiums, copayments, deductibles…the terminology may lead to confusion for Medicaid consumers who move to the Exchange. The cost obligations may be overwhelming and lead them not to purchase coverage.

Annual Income	%FPL (Family Size 1)	Eligibility	Premium (after subsidy)	Expected Cost Sharing	Total Out of Pocket
$14,702	135%	Medicaid	$0	$0	$0
$15,246	140%	Exchange	$518	$343	$861

Consumers will enter and have their eligibility determined via the Exchange. A modest change in income, in this example and increase of $544 pre-tax dollars annually, can lead to a substantial increase in an individuals cost obligation (in this case $861 annually in after-tax dollars).

Potential Levers to Address "Churn"

UnitedHealthcare COMMUNITY & STATE

Potential Levers and Requirements	Policy	Product	Tool
End to End Eligibility, Recertification and Enrollment Via Exchange			✓
Align the Benchmark and Essential Health Benefits	✓		
The Basic Health Plan		✓	
Common Health Plans across Medicaid, The Exchange, and BHP	✓		
Common Providers across Medicaid, The Exchange and BHP	✓		
A Focus on Affordability, the Right Price Points		✓	
Special Enrollment Rules For Health Plans that Operate In Medicaid & The Exchange	✓		✓
Same Member ID Card For All Programs			✓
Pro-Actively Track and Conduct Outreach to Help Families In Transition, including Health Insurance Literacy			✓
Consistent Enrollment Rules, Timeframes, and Definitions for Medicaid and the Exchange	✓		✓